FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041640

Facility Name: Heartland Health Care Center-Paxton

Address: 1001 East Pells Street (Number) Paxton (City) 60957 (Zip Code)

County: Ford

Telephone Number: (217) 379-4361 **Fax #** (217) 379-3325

HFS ID Number: 344402510014

Date of Initial License for Current Owners: 10/03/1988

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	18,801	10,740	29,541	8
9	SNF/PED					9
10	ICF	3,479			3,479	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,479	18,801	10,740	33,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.24%

D. How many bed-hold days during this year were paid by the Department?
12 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/03/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 96 and days of care provided 7,886

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	191,405	18,124	14,926	224,455	2,428	226,883		226,883			1
2	Food Purchase		161,094		161,094		161,094	(9,082)	152,012			2
3	Housekeeping	81,963	9,086	654	91,703		91,703		91,703			3
4	Laundry	31,470	6,421	373	38,264		38,264		38,264			4
5	Heat and Other Utilities			116,118	116,118	4,913	121,031	(10,206)	110,825			5
6	Maintenance	57,545	7,733	44,560	109,838		109,838		109,838			6
7	Other (specify):* **Med Waste**			696	696		696		696			7
8	**TOTAL General Services**	362,383	202,458	177,327	742,168	7,341	749,509	(19,288)	730,221			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	1,664,702	111,824	55,055	1,831,581	8,814	1,840,395	(4,235)	1,836,160			10
10a	Therapy	20,464	4,825	492,265	517,554		517,554		517,554			10a
11	Activities	85,245	3,651	3,151	92,047		92,047		92,047			11
12	Social Services	81,980	774	3,491	86,245		86,245		86,245			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,852,391	121,074	574,362	2,547,827	8,814	2,556,641	(4,235)	2,552,406			16
	C. General Administration											
17	Administrative	128,057		295,619	423,676	(66,639)	357,037		357,037			17
18	Directors Fees											18
19	Professional Services			6,999	6,999	(1,620)	5,379	(5,379)				19
20	Dues, Fees, Subscriptions & Promotions			59,064	59,064		59,064	(38,018)	21,046			20
21	Clerical & General Office Expenses	169,676	46,617	187,909	404,202	1,620	405,822	(152,291)	253,531			21
22	Employee Benefits & Payroll Taxes			482,164	482,164	36,618	518,782		518,782			22
23	Inservice Training & Education			2,813	2,813		2,813		2,813			23
24	Travel and Seminar			20,202	20,202		20,202		20,202			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,211	94,211		94,211		94,211			26
27	Other (specify):* **Pers Purch**			175	175		175	(175)				27
28	**TOTAL General Administration**	297,733	46,617	1,149,156	1,493,506	(30,021)	1,463,485	(195,863)	1,267,622			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,512,507	370,149	1,900,845	4,783,501	(13,866)	4,769,635	(219,386)	4,550,249			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Health Care Center-Paxton #0041640 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			399,025	399,025	13,866	412,891		412,891			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,664	38,664		38,664	(78)	38,586			32
33	Real Estate Taxes			64,120	64,120		64,120	(5,155)	58,965			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,985	40,985		40,985		40,985			35
36	Other (specify):* G/L Assets			12,024	12,024		12,024	(12,024)				36
37	**TOTAL Ownership**			554,818	554,818	13,866	568,684	(17,257)	551,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		262,181	71,277	333,458		333,458		333,458			39
40	Barber and Beauty Shops	53	1,070	16,134	17,257		17,257		17,257			40
41	Coffee and Gift Shops	561			561		561		561			41
42	Provider Participation Fee			53,330	53,330		53,330		53,330			42
43	Other (specify):* IV Therapy		49,312		49,312		49,312		49,312			43
44	**TOTAL Special Cost Centers**	614	312,563	140,741	453,918		453,918		453,918			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,513,121	682,712	2,596,404	5,792,237		5,792,237	(236,643)	5,555,594			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,082)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,206)	5		5
6	Rented Facility Space	(7)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(78)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	1,581	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,134)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,983)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,379)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(151,347)	21		24
25	Fund Raising, Advertising and Promotional	(38,018)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,155)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,835)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (236,643)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,643)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Health Care Center-Paxton

ID# 0041640

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	G/L Assets	$ (12,024)	36	1
2	Customer Reimbursement	(535)	21	2
3	Personal Purchase	(175)	27	3
4	Purchase Svc - Psych Service	(2,101)	10	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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27				27
28				28
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,835)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,082)	0	0	0	0	0	0	0	0	0	0	(9,082)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,206)	0	0	0	0	0	0	0	0	0	0	(10,206)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,288)	0	0	0	0	0	0	0	0	0	0	(19,288)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,235)	0	0	0	0	0	0	0	0	0	0	(4,235)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,235)	0	0	0	0	0	0	0	0	0	0	(4,235)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,379)	0	0	0	0	0	0	0	0	0	0	(5,379)	19
20	Fees, Subscriptions & Promotions	(38,018)	0	0	0	0	0	0	0	0	0	0	(38,018)	20
21	Clerical & General Office Expenses	(152,291)	0	0	0	0	0	0	0	0	0	0	(152,291)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(175)	0	0	0	0	0	0	0	0	0	0	(175)	27
28	**TOTAL General Administration**	(195,863)	0	0	0	0	0	0	0	0	0	0	(195,863)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(219,386)	0	0	0	0	0	0	0	0	0	0	(219,386)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heartland Health Care Center-Paxton **#** 0041640 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(78)	0	0	0	0	0	0	0	0	0	0	(78)	32
33	Real Estate Taxes	(5,155)	0	0	0	0	0	0	0	0	0	0	(5,155)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(12,024)	0	0	0	0	0	0	0	0	0	0	(12,024)	36
37	**TOTAL Ownership**	(17,257)	0	0	0	0	0	0	0	0	0	0	(17,257)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(236,643)	0	0	0	0	0	0	0	0	0	0	(236,643)	45

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 295,619	HCR Manor Care, Inc	100.00%	$ 295,619	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	9,341	Heartland Management Services	100.00%	9,341		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 304,960			$ 304,960	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	$ 1,107,111	$ 591,572	5,486,398	$ 2,428	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			5,486,398	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		5,486,398	587	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		5,486,398	4,326	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	5,486,398	1,692	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	5,486,398	7,122	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,065	22,717,176	5,486,398	54,365	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	5,486,398	174,615	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		5,486,398	13,955	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		5,486,398	22,663	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			5,486,398	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		5,486,398	13,866	12
13										13
14	32	Interest								14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 156,573,724	$ 69,154,917		$ 295,619	25

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	National City Bank, Trustee		X	Finance Capital Additions	N/A		$ 618,583	$ 618,583			$ 38,664	1
2												2
3												3
4								Income			(78)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 618,583	$ 618,583			$ 38,586	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 618,583	$ 618,583			$ 38,586	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Paxton **#** 0041640 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	69,275	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	64,120	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,155)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	64,120	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,965	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000	52,590	8
2001	55,180	9
2002	60,217	10
2003	60,734	11
2004	64,120	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Paxton COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0041640

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-08-476-001	See Attached	$ 64,120.02	$ 64,120.02
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,120.02	$ 64,120.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,919 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 75,186	1
2					2
3	TOTALS			$ 75,186	3

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	79		1988	1988	$ 2,518,385	$ 146,449		$ 146,449	$	$ 1,273,734	4
5	Audit Adj (#1) - Overhead & Int			1998	(65,930)						5
6	8			2001	440,268						6
7	Audit Adj (#2) - Various			2001	(33,214)						7
8				2003	629,640						8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					136,411		136,411		643,319	9
10	Land/Bldg. Improvement (See attached schedule)			1988	279,229						10
11	Additional Attic Insulation			1989	3,500						11
12	Fire Alarm System			1990	294						12
13	Audit Adj (#3) - Fire Alarm System			1990	(294)						13
14	Land/Bldg. Improvement (See attached schedule)			1990	8,348						14
15	Land/Bldg. Improvement (See attached schedule)			1991	6,404						15
16	Land/Bldg. Improvement (See attached schedule)			1992	24,904						16
17	Land/Bldg. Improvement (See attached schedule)			1993	12,778						17
18	Land/Bldg. Improvement (See attached schedule)			1994	1,010						18
19	Land/Bldg. Improvement (See attached schedule)			1995	14,522						19
20	BATHTUB			1996	356						20
21	(7) DOORS			1996	3,896						21
22	WALLCOVERING			1996	1,133						22
23	CARPET & WALLCOVERING			1996	2,199						23
24	CEILING			1997	2,101						24
25	WALLCOVERING			1997	8,139						25
26	WALLCOVERING			1997	22						26
27	CREDIT ON BLD IMP-CNCLD RETAIN			1997	(434)						27
28	WALLCOVERING			1997	13,695						28
29	CARPET			1997	1,081						29
30	WALLCOVERING			1997	1,571						30
31	ENGINEERING AND ARCHITECTURAL FEES			1997	75,055						31
32	Audit Adj (#4) - Various			1997	(22,168)						32
33	(14) PKG AMANA A/C UNITS			1997	9,051						33
34	PAINTING			1997	10,933						34
35	PAINTING & WALLCOVERING			1997	7,933						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NURSE CALL SYSTEM	1997	$ 2,561	$		$	$	$	37
38	VINYL WALL COVERING FROM INVENTORY	1997	293						38
39	VINYL WALL COVERING FROM INVENTORY	1997	187						39
40	VINYL WALL COVERING FROM INVENTORY	1997	814						40
41	CUBICLE CURTAIN TRACK	1997	1,416						41
42	NURSE CALL SYSTEM UPGRADE	1997	2,305						42
43	WALLCOVERING	1997	157						43
44	CROWN MOLDING & CHAIR RAIL	1997	820						44
45	GARAGE WOOD	1997	12,983						45
46	ADDL'T COST FOR NURSE CALL SYSTEM #15	1998	167						46
47	WALLCOVERING	1998	191						47
48	COVE BASE	1998	1,529						48
49	WALLCOVERING	1998	75						49
50	DOOR ALARMS	1998	3,598						50
51	WALLCOVERING	1998	249						51
52	SECURE CARE LOCKS	1998	11,971						52
53	ADDL'T NURSE CALL SYSTEM	1998	1,901						53
54	WALLPAPER FROM CONSTRUCTION	1998	196						54
55	GATE	1998	390						55
56	A/C UNIT	1998	1,925						56
57	HVAC FOR ADDITION	1998	47,008						57
58	AUDIT ADJ (#5) - VARIOUS	1998	(6,158)						58
59	BRASH BARRY GENERAL CONSTRUCTION	1998	23,132						59
60	REMOVE OVERHEAD PAGING	1998	338						60
61	WALLCOVERING	1998	7,678						61
62	CABINETRY & COUTNERTOPS	1998	8,240						62
63	CARPENTRY	1998	24,126						63
64	ELECTRICAL WORK	1998	444						64
65	ELECTRICAL WORK	1998	32,894						65
66	LIGHT FIXTURES	1998	1,253						66
67	PLUMBING WORK	1998	711						67
68	LAWNCARE SEEDED CONSTRUCTION AREA	1998	440						68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,138,241	$ 282,860		$ 282,860	$	$ 1,917,053	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,138,241	$ 282,860		$ 282,860	$	$ 1,917,053	1
2	SPRINKLER SYSTEM	1998	45,812						2
3	FIRE ALARM SYSTEM	1998	3,370						3
4	FENCE	1998	6,507						4
5	PAVING	1998	38,079						5
6	CONSTRUCTION AND DESIGN OVERHEAD COST	1999	114,792						6
7	AUDIT ADJ (#6) - OVERHEAD COST	1999	(114,792)						7
8	DIRECT VENT UNIT HEATER	1999	1,556						8
9	SECURE CARE LOCKING SYSTEM	1999	958						9
10	SEAL & STRIPE PARKING LOT	1999	3,136						10
11	EXTERIOR LIGHTING	1999	20,250						11
12	SINK & FAUCET	2000	596						12
13	NURSES STATION	2000	11,790						13
14	COUNTERTOP	2000	1,200						14
15	VCT	2000	1,140						15
16	WATER HEATER	2000	3,780						16
17	NURSES STATION	2000	475						17
18	PAINTING	2000	11,005						18
19	CUSTOM CABINETS	2000	7,091						19
20	INSTALL CARPET	2001	593						20
21	GAZEBO	2001	4,319						21
22	CARPENTRY-ARCADIA RENOV	2001	16,430						22
23	CARPENTRY-ARCADIA RENOV	2001	13,084						23
24	AUDIT ADJ (#7) - CARPENTRY	2001	(1,469)						24
25	LANDSCAPING-ARCADIA RENOV	2002	21,295						25
26	AUDIT ADJ (#2) - TRANSFER TO BUILDING	2002	(21,295)						26
27	PAINTING	2002	7,175						27
28	PAINTING	2002	825						28
29	DRAPES	2002	130						29
30	FLOORING,VINYL WALL COVERING	2002	8,405						30
31	OUTDOOR LIGHTING	2002	1,560						31
32	DOORS	2002	5,900						32
33	HALLWAY PAINT AND BORDER	2002	1,150						33
34	TOTAL (lines 1 thru 33)		$ 4,353,088	$ 282,860		$ 282,860	$	$ 1,917,053	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,353,088	$ 282,860		$ 282,860	$	$ 1,917,053	1
2	MDS OFFICE-VINYL WALL COVERING	2003	419						2
3	AUDIT ADJ (#9) - VWC	2003	(25)						3
4	MDS OFFICE-PAINTING & VINYL WALL COVERING	2003	945						4
5	MDS OFFICE-RETAINAGE-PAINTING & VWC	2003	105						5
6	MDS OFFICE-ELECTRIC WORK	2003	1,338						6
7	MDS OFFICE-BORDER	2003	66						7
8	AUDIT ADJ (#10) - BORDER	2003	(4)						8
9	CARPET	2003	1,051						9
10	SNF ADDITION-ARCHITECT COSTS	2003	4,612						10
11	OUTLETS IN DINING ROOM	2003	1,280						11
12	RESILIENT FLOORING	2004	17,087						12
13	SECURITY DOOR	2004	5,354						13
14	WATER,SEWER,UTILITIES FOR ADDITION	2003	44,792						14
15	TESTING GEOTECHNICAL	2003	3,519						15
16	SECURITY DOOR	2005	4,932						16
17	ENGINEERING, ARCHITECTURAL FEES	2003	156,819						17
18	VINYL WALL COVERING, FLOORING	2003	12,441						18
19	VINYL WALL COVERING, FLOORING (ADJUSTMENT)	2003	(75)						19
20	MILLWORK	2003	2,815						20
21	NEW ROOF	2005	88,184						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,698,743	$ 282,860		$ 282,860	$	$ 1,917,053	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,204,000	$ 116,166	$ 116,166	$		$ 908,282	71
72	Current Year Purchases	180,754						72
73	Fully Depreciated Assets							73
74	H/O Allocation			13,866	13,866			74
75	TOTALS	$ 1,384,754	$ 116,166	$ 130,032	$ 13,866		$ 908,282	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,158,683	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 399,026	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 412,892	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,866	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,825,335	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 40,985 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	323	hrs	$ 9,938		$ 174,844	$ 1,857	323	$ 186,639	1
2	Licensed Speech and Language Development Therapist	10a	139	hrs	4,274		67,243	69	139	71,586	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	203	hrs	6,252		250,044	2,899	203	259,195	4
5	Physician Care			visits							5
6	Dental Care	39		visits			3,300			3,300	6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				262,181		262,181	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S-Lab,X-Ray	10,Col 3,39					68,111			68,111	13
14	TOTAL				$ 20,464		$ 563,542	$ 267,006	665	$ 851,012	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,868	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (183,886))	954,709		3
4	Supply Inventory (priced at)	23,327		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	536		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 987,440	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,186		13
14	Buildings, at Historical Cost	4,698,741		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,384,755		16
17	Accumulated Depreciation (book methods)	(2,825,335)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,333,347	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,320,787	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 21,001	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	224,696		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,120		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	76,532		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 386,349	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	618,583		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	20,117		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 638,700	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,025,049	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,295,738	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,320,787	$	48

***(See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,138,432	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,138,432	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	889,599	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 889,599	17	
	B. Transfers (Itemize):			
18	**Change in Interdivision**	(732,293)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (732,293)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,295,738	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,333,815	1
2	Discounts and Allowances for all Levels	(270,377)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,063,438	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,273,392	6
7	Oxygen	510	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,273,902	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	857	12
13	Barber and Beauty Care	20,611	13
14	Non-Patient Meals	8,079	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7	16
17	Sale of Drugs	273,058	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,405	19
20	Radiology and X-Ray	23,532	20
21	Other Medical Services	2,869	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 344,418	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	65	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 65	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,681,836	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	742,168	31
32	Health Care	2,547,827	32
33	General Administration	1,493,506	33
	B. Capital Expense		
34	Ownership	554,818	34
	C. Ancillary Expense		
35	Special Cost Centers	453,918	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,792,237	40
41	**Income before Income Taxes (line 30 minus line 40)****	889,599	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 889,599	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,709	1,855	$ 51,986	$ 28.02	1
2	Assistant Director of Nursing	3,786	4,111	104,140	25.33	2
3	Registered Nurses	15,172	16,475	334,440	20.30	3
4	Licensed Practical Nurses	19,986	21,703	413,153	19.04	4
5	CNAs & Orderlies	68,451	74,332	736,838	9.91	5
6	CNA Trainees					6
7	Licensed Therapist	609	665	20,464	30.77	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,148	8,866	85,245	9.61	10
11	Social Service Workers	4,929	5,370	81,980	15.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,795	20,429	191,405	9.37	15
16	Dishwashers					16
17	Maintenance Workers	3,818	4,146	57,545	13.88	17
18	Housekeepers	7,956	8,649	81,963	9.48	18
19	Laundry	3,701	4,021	31,470	7.83	19
20	Administrator	2,090	2,090	80,249	38.40	20
21	Assistant Administrator	1,947	1,947	47,808	24.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,072	11,831	170,290	14.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,782	1,934	24,145	12.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,951	188,424	$ 2,513,121 *	$ 13.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	20,400	Line 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,400		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scharp, Cynthia S	Administrator	0	$ 80,249
Diana Porter	Assist Admin	0	47,808
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 128,057

B. Administrative - Other

Description	Amount
Home Office	$ 295,619
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 295,619

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand & Elvidge Kelly	Legal	5,379
Accounting Fees	Accounting	1,620
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 6,999

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,018
Unemployment Compensation Insurance	51,309
FICA Taxes	177,468
Employee Health Insurance	180,070
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	12,546
401K / SMSP Match	11,769
Employee Vaccination	516
Employee Uniforms	2,470
Payroll Overhead Allocation	(2)
Home Office Allocation	36,618
TOTAL (agree to Schedule V, line 22, col.8)	$ 518,782

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 478
Advertising: Employee Recruitment	5,009
Health Care Worker Background Check (Indicate # of checks performed 218)	4,351
Dues & Subscriptions	3,552
Association Dues	5,423
Marketing	20
Advertising	40,231
Less: Non-Allowable Association Dues	(1,788)
Less: Public Relations Expense	(20)
Non-allowable advertising	(36,210)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,046

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	20,202
Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,202

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland Health Care Center-Paxton # 0041640 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 5,423**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 1,788**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,860** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,330**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(8,079)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.